Response to Draft Report "San Jose Medical Center Site Options: Health Care Issues"
Draft Report Dated April 18, 2007

Response Prepared By Regional Medical Center of San Jose
May 2, 2007

Introduction

A draft report entitled "San Jose Medical Center Site Options: Health Care Issues" has been prepared by Henry Zaretsky, PhD and Associates for the San Jose Medical Center Stakeholder Advisory Committee. The draft is dated April 18, 2007.

This report is provided as a response to the Zaretsky draft report with a request that Dr. Zaretsky and the Stakeholder Advisory Committee consider revisions based on the information provided here.

Regional Medical Center of San Jose prepared a report entitled "Commitment to Serving Downtown San Jose." The report was submitted to the Stakeholder Advisory Committee (SAC) and Dr. Zaretsky at the SAC meeting on April 18, 2007.

Overview

There is significant similarity between the "Actions for Consideration" in the Zaretsky draft and the analysis, plans and commitments of Regional Medical Center as outlined in the RMCSJ report of April 18. The two reports were prepared independently and submitted to the SAC at the same meeting.

While there is significant agreement between the two reports, some of the suggestions for consideration in the Zaretsky draft are ones that would create major public policy problems.

Primary Care and Urgent Care

The Zaretsky draft suggests consideration of the development of primary and urgent care services on a portion of the site (with the rest of the site for non-healthcare development) or adjacent to the site in an existing medical office building. Regional Medical Center of San Jose concurs with this recommendation. As stated in its April 18 report, RMCSJ is prepared to operate an urgent care center and a diagnostic center on a portion of the site (or in a medical office building adjacent to the site). Further, RMCSJ seeks the rezoning of the balance of the site for non-healthcare development.

The Zaretsky draft suggests that a new urgent care center should be required to accept MediCal patients. RMCSJ would like to be able to provide urgent care services; however, it is not willing to commit to treat any significant category of patients.

There are significant challenges associated with providing urgent care services to

MediCal patients. Indeed, the Zaretsky draft reports that the urgent care service now operating near the site does not accept MediCal patients. The draft does not take note of the fact that the Gardner Family Health Network (which does provide extensive primary care services to MediCal patients) does not currently provide urgent care services and is not willing to provide them at or near the site.[1] It may be that Gardner (which is able to provide routine outpatient care to MediCal patients) is not willing to provide urgent care services because of the even higher costs of urgent care when compared to the cost of routine care. Additionally, it should be noted that one of the reasons that Gardner is able to provide extensive services to MediCal patients and other low-income groups is that it is a Federally Qualified Heath Center (FQHC) and is, therefore, entitled to higher levels of payment based on a special payment formula. Based on preliminary research, there is not an organizational structure in which RMCSJ could operate an urgent care center with this payment formula.

The reason that so many providers are unwilling to commit to offer urgent care services to MediCal patients is that current rates of payment for outpatient physician services are so low.[2]

MediCal

The Zaretsky draft suggests that it would be desirable for RMCSJ to be able to provide comprehensive services to MediCal beneficiaries. RMCSJ concurs with this goal and is committed to take reasonable steps to achieve this goal. RMCSJ negotiated diligently with the MediCal program over the last two years to try to arrive at a payment rate that would allow for financial feasibility. The negotiating position of the MediCal program was (in the experience of RMCSJ and HCA) unreasonable.[3] RMCSJ will seek again to re-establish a MediCal contract in the years ahead. In anticipation of eventual success in this effort, RMCSJ has planned its facility expansion (currently under construction) to accommodate full MediCal volume. Moreover, it should be noted that, even without a contract for elective inpatient MediCal services, RMCSJ provides a significant level of services to MediCal patients (slightly higher than O'Connor).

The Zaretsky draft suggests that the City should consider pressuring RMCSJ through such mechanisms as zoning and City insurance contracts covering City employees to execute a contract with MediCal. RMCSJ believes that this would be an improper interference of local government in operational business activities of a local business. State law prohibits either party to MediCal contract negotiations from revealing terms of agreements or negotiation to any third party. Therefore, it would be impractical for the City to monitor such negotiations. Additionally, this approach would be based on the assumption that it is RMCSJ (rather than MediCal) that requires pressure to agree to different terms. The Zaretsky draft provides no substantiation for this assumption.

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[1] Source: Personal communication from Reymundo Espinoza, CEO, Gardner Family Health Network.
[2] For most all outpatient physician services (e.g., CPT 99201-99215) MediCal pays between 51% and 69% *below* what Medicare pays; Medicare in turn pays significantly less than most private insurance plans pay.
[3] RMCSJ had years of successful experience in negotiating contracts with the MediCal program. Good Samaritan Hospital (another local HCA hospital) currently has a MediCal contract.

Further, as stated in the Zaretsky draft: "A major defect in this approach is that the MediCal payers across the table from Regional during the contract negotiations could gain an unfair negotiating advantage." RMCSJ believes that this is more than a case in which MediCal *could* gain an unfair advantage: Such a compulsion *would* give MediCal an unfair advantage. Indeed, such an approach would violate the principle and definition of fair market value: "the price…between a willing buyer and willing seller, *neither being under compulsion to act* (emphasis added) and both having reasonable knowledge of all the relevant facts."[4]

Finally, it should be kept in mind that (as detailed in the RMCSJ report of April 18) any issues of access for MediCal patients to RMCSJ are limited to elective inpatient care. Even without a MediCal contract, RMCSJ is able to provide full access to emergency inpatient and outpatient care and all other outpatient care.

The draft report asserts: "The abrupt closure of San Jose Medical Center (SJMC) in late 2004 left a gap in health-care services readily accessible to residents of the downtown area." The report asserts that the gap is comprised of five components. Those components, prioritized from lowest to highest are, according to the report:

1. Trauma center relocation
2. Loss of general acute care beds
3. Loss of emergency services at SJMC
4. Loss of non-emergency care outpatient capacity
5. Specialists with offices near SJMC moving to locations adjacent to other hospitals

The draft Zaretsky report provides the following context:

> "The plan on the part of SJMC's owners (HCA) was to consolidate services (including the trauma center) at Regional Medical Center, some 2.5 miles away. While from health-planning and economic perspectives this plan makes sense, it still represents a worsening in the status quo for many downtown residents, and for those residents in need of care without ready access to private transportation, it represents a hardship."

Regional Medical Center of San Jose concurs with the Zaretsky draft that the consolidation of the two hospitals makes sense from both a health planning and economic perspective. Indeed, RMCSJ found that with the consolidation it would not have been possible for *either* hospital to remain operational.[5]

Therefore, consolidation of SJMC and RMCSJ has helped *secure* access to care for downtown residents (and residents of Eastern Santa Clara County), not worsen it.

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[4] 26 C.F.R. sec. 20.2031-1(b)

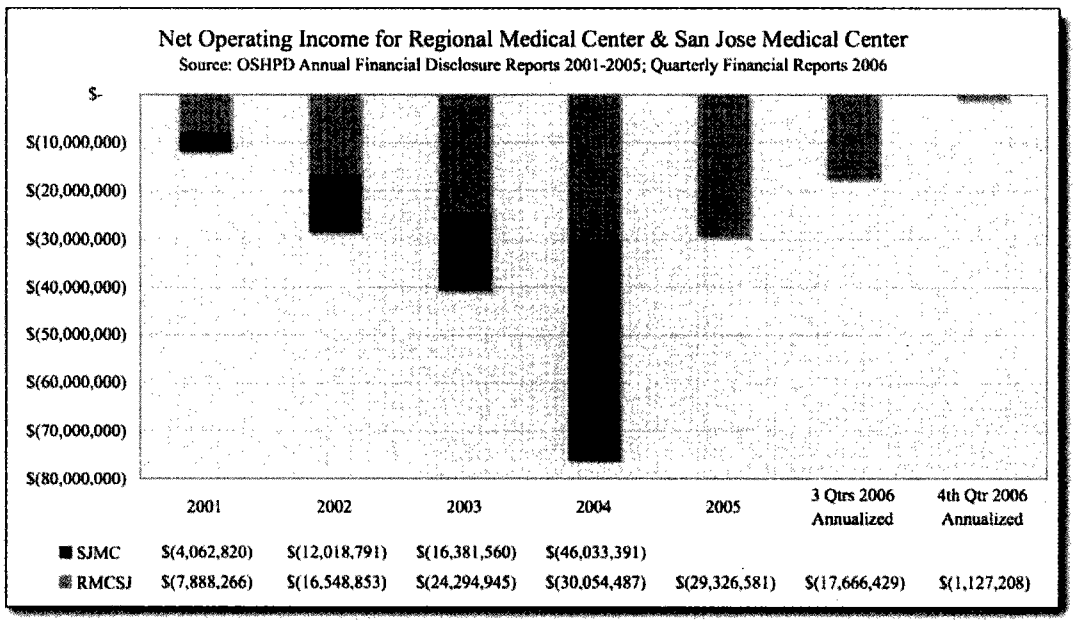
[5] Financial information substantiating this finding is provided in the report submitted by RMCSJ on April 18, 2007.

New Hospital

The Zaretsky draft suggests consideration of designating approximately 5 acres of the site (or at another downtown location). There are four problems with this suggestion:

1. Establishing another new hospital in downtown San Jose will threaten access to care for both downtown residents and patients, reversing the progress made by RMCSJ to develop an economically self-sufficient hospital and re-establishing two financially unsustainable hospitals. In RMCSJ's "Commitment to Serving Downtown San Jose" report it was noted that unification of the programs of SJMC and RMCSJ would be successful in bringing about a financially sustainable hospital to serve the central and eastern portions of the County. A chart was presented in which 2006 preliminary data was based upon annualizing 3 quarters of data taken from the OSHPD Quarterly Financial Reports.

   The week of April 22nd fourth quarter results released by OSHPD demonstrate the dramatic improvement that is continuing to be made by the unification of SJMC and RMCSJ. The chart below is an update to the one provided in the RMCSJ "Commitment to Serving Downtown San Jose" April 18 report.



   The 2004 losses are somewhat overstated because, with the wind down of SJMC and the transfer of services to RMCSJ, this was a year of transition with extraordinary costs. What this chart demonstrates is that the financial performance of both SJMC and RMCSJ was deteriorating between the years 2001 to 2004 and that it would not be financially feasible to continue operating two hospitals 3 miles apart in central and eastern Santa Clara County. Financial performance has shown a substantial improvement since the SJMC closure. The unification of the two hospitals is now leading to financial sustainability.

2. As shown in the RMCSJ report of April 18, five acres is insufficient for a modern acute care hospital. Even ten acres is insufficient for a modern hospital with reasonable allowances for important associated services and flexibility for future replacement, growth and adaptation.
3. As shown in the RMCSJ report of April 18, there is no need for a hospital in downtown San Jose—either to provide additional total bed capacity or to provide access to emergency care.
4. If RMCSJ were weakened by a duplicative and unnecessary hospital, the community would lose one of its trauma centers, in addition to losing the services of the hospital generally.

Review of Detailed Findings in the Zaretsky Draft

Trauma Center Relocation

The Zaretsky draft report identifies trauma center care as a category of gap in access; however, it goes on to state that there are currently 2 trauma centers within a 7.3-mile radius of the SJMC site. It is not clear why the Zaretsky draft even discusses trauma as a service gap. Transport times from all portions of the County for all categories of emergency care (including trauma center care) are well within standard emergency care planning guidelines. Further, as shown in the RMCSJ report of April 18, transport time for all emergency care (including trauma care) for downtown communities is less than the average transport time for all other communities within the County.

The Zaretsky draft states that the Level I trauma center at VMC is more comprehensive than the Level II center at RMCSJ. This is potentially misleading. With respect to virtually all categories of care for adults with critical injuries, Level I and Level II centers have the same capability. The only difference between a Level I and Level II center is that Level I centers staff with physicians in-training (as well as fully trained physicians) and conduct some research, whereas Level II centers staff only with fully trained physicians. The only patient care differences between VMC and RMCSJ for trauma care are that VMC also handles pediatric trauma and major burns.

Loss of General Acute Care Beds

The Zaretsky draft suggests that a gap in access is created by the loss of beds at SJMC. At the same time, however, the draft provides information indicating that there is no bed capacity problem even after the closure of SJMC.

The Zaretsky draft states that planned increases at RMCSJ and available beds at O'Conner Hospital and Valley Medical Center could accommodate downtown needs until 2015-2020.

RMCSJ concurs with this portion of the findings in the Zartetsky draft.

The Zaretsky draft shows that SJMC had an average occupancy of 33% in its last few years of operation and only 1/3 of SJMC patients resided in the downtown area. Thus, it is evident that SJMC did not provide a significant level of access to inpatient care for downtown residents and that capacity at other nearby hospitals (RMCSJ, O'Connor, VMC and Kaiser) can do a good job of meeting many of these needs.

Loss of Emergency Services at SJMC

The Zaretsky draft states that downtown residents must now travel farther and there is a potential for overcrowding at O'Conner, Valley Medical Center and RMCSJ. While downtown residents must now travel farther to the nearest hospital, the RMCSJ report of April 18 shows that downtown residents still have less travel time to nearby hospitals than more than half of the zip codes in Santa Clara County. The increase in travel does not constitute a gap in healthcare services.

Potential for overcrowding at O'Conner, Valley and RMCSJ is just that – potential. There is no evidence to suggest that this potential has become reality; therefore, there is not a gap in healthcare services. Additionally, the recommendation in the Zaretsky report (supported by RMCSJ) for an urgent care center at the site of SJMC would help improve access for the portion of emergency department care that can be appropriately handled in an urgent care center.

Loss of Non-Emergency Care Outpatient Capacity

The Zaretsky draft identifies non-emergency outpatient care as a gap in access with a particular focus on primary care, urgent care and diagnostic services. RMCSJ concurs and is prepared to operate an urgent care center and a diagnostic center. The Zaretsky draft suggests that all new services should accept all payer groups. RMCSJ concurs with the goal of comprehensive access and will take all reasonable steps to provide such access, but is not able to agree to accept a requirement that it be compelled to agree to payment rates that could be set at any level by a payer such as MediCal. As noted above, such a requirement would conflict with principles of fair market value.

<u>Specialists Moving to Locations Adjacent to Other Hospitals</u>

The Zaretsky draft identifies loss of specialty physicians associated with the closure of SJMC. It is correct that specialist physicians have relocated and are relocating from offices near the site. Most specialist physicians want to be located at or near hospitals.

The greater San Jose area has an adequate number of specialist physicians. The changes associated with the closure of SJMC are relocations and re-allocations of this overall supply. In a community such as the greater San Jose area with an adequate overall supply of specialist physicians, an analysis of access to hospitals is the same thing as an analysis of access to specialists.

The Zaretsky report notes that creating a multi-specialty group is a major undertaking and that it is not likely that an investor would emerge to attempt such a creation. RMCSJ concurs with this finding; however, RMCSJ has concluded that the most practical strategy to encourage the maximum number of specialist physicians to remain near the site (or to establish new offices near the site) is to pursue the following development plan:

- Establish a new urgent care center at or near the site;
- Develop a high quality mixed use development on the majority of the site including residential, retail and commercial.